ECHN℠
Eastern Connecticut Health Network

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TESTIMONY OF
Eastern Connecticut Health Network
[Manchester Memorial & Rockville General Hospitals]
Deborah A. Parker
Senior Vice President for Patient Care Services
BEFORE THE
PUBLIC HEALTH COMMITTEE
Monday, March 1, 2010

SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient Surgical Facilities

My name is Deborah Parker and I am the Senior Vice President for Patient Care Services at the Eastern Connecticut Health Network (ECHN), which includes Manchester Memorial Hospital and Rockville General Hospital. I appreciate the opportunity to testify in opposition to **SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient Surgical Facilities.**

ECHN opposes the bill because the changes proposed to the adverse event reporting system do not improve the quality of care or patient safety. Confidential reporting is imperative in promoting a culture of safety and encouraging open and honest communication among clinicians with the ultimate goal of improving every patient interaction and every patient experience.

At ECHN, we have worked deliberately and diligently to create an environment that fosters quality patient care and patient safety. As one of its five strategic pillars, Quality and Safety is the priority of every ECHN employee. Through the practice of proactive risk assessments, failure mode and effects analyses and root cause analyses, ECHN employees are encouraged to take an active role in identifying opportunities for enhanced patient safety and quality. This has been accomplished because of the non-punitive approach to the promotion of improvement. As an active member of the Patient Safety Organization, ECHN has participated in numerous collaborative initiatives to improve patient quality and safety. These have included, but are not limited to pressure ulcer prevention, fall prevention, central line bacteremia prevention and the reduction of health care acquired MRSA. I know our success have come through the open sharing of experiences and best practices. Evidence has shown that a system that fosters patient safety by having confidential reporting of adverse events in a non-punitive environment encourages the reporting of these events. I am incredibly fearful that a change to a system that is not confidential and one that imposes civil penalties and other punitive measures will be counterproductive in continuing all of these positive initiatives. ECHN, along with the other Connecticut hospitals work very hard every day to prevent errors from occurring. But when they do occur, we investigate them promptly and thoroughly, search to identify the root cause, and develop detailed action plans to prevent recurrence. We then monitor those plans and make additional corrections as necessary. Simply said, taking away confidentiality in adverse event reporting will only undo the measures Connecticut hospitals have taken thus far to provide quality care and a safe environment for their patients.

ECHN respectfully asks that any and all changes that are contemplated to the adverse event reporting system be carefully considered to ensure that the end result is improved patient care.

Thank you for consideration of our position.